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GROUP MEETING ON MENTAL HEALTH AND MENTAL LEGISLATION
Cairo, 12 to 17 June 1976

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ONGOING MECHANISM OF REVIEW

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1. Introduction

In many parts of the world, the mentally disordered are an under-priviledged minority, with no access to modern, effective treatment, usually denied the means of daily living and frequently excluded from their social group. It can hardly be argued that this is primarily because of absent or defective law. Societies, faced with individuals behaving in a strange, frightening and disruptive manner, have reacted to the situation in a pragmatic (even if "inhuman") way. In those communities where effective traditional forms of care are available, exclusion and ill-treatment of the mentally ill are less common. The challenge is, therefore, how, with limited resources, more effective responses to mental disorders can be generated, partly through improved health services but also by changing public reactions leading to an extension of coverage of mental health care. Even in those countries devoting considerable resources to mental health services, some patient groups are clearly underserved (for example, the mentally retarded, the chronic psychotic and the elderly with mental disorders), particularly at the community level. What is therefore needed is a process of change, in which mental health legislation can play an important part, leading on the one hand to wider application of methods of treatment, control and care and, on the other hand, to increased community involvement in helping and accommodating mentally ill people.

A central theme in the main document is the relationship between mental health legislation, programme objectives and public attitudes. This derives from a general, philosophical viewpoint of the law as neither a static nor an isolated phenomenon and as dependent on a variety of societal factors. The law cannot itself lay down moral standards or create human rights. It can, however, define, protect and uphold such rights and standards. Furthermore, it has an important educational function.

An evolutionary approach to mental health law may therefore be necessary, with a progression of statutes matching (or, perhaps, more properly "leading") the development of mental health services in a particular country. In any case, some further changes in the law are likely to be necessary even after a thoroughgoing assessment and modernization of the law. All legal systems make provision for changing statute law through amendments, repeal and re-enactment; changes can also occur through administrative measures and through fresh interpretation of the law by the courts. It follows that a method of ongoing evaluation of mental health legislation is needed, so that timely and appropriate changes can be made.

2. Possible vehicles for the review mechanism

a) Statutory commissions, etc.

In theory, it is the responsibility of the legislature itself to seek information which might indicate the need for statutory change. This may happen, in the field of mental health legislation, through the setting up of commissions, standing committees or through debates of the legislature itself. Perhaps the best known examples are theRoyal Commissions in the United Kingdom, particularly the two most recent in 1924-26 and 1954-57. The advantages of this procedure were the considerable attendant publicity, the weight attached to the recommendations in view of the commissions' prestige, the involvement of a wide range of interests and the careful and comprehensive review of the field which could be carried out. The recommendations of both commissions led to major statutory changes, which met with wide approval. The disadvantages of such commissions, particularly for regular review are their expense, their cumbersomeness and their rigidity. In the former case, the public hearings of the commission developed into a quasi-court proceeding, with patients making detailed accusations of wrongful detention and ill treatment. This leads, in fact, to the central weakness of the time-limited commission (or similar body) as a review mechanism: its lack of control over information input. It must rely upon post hoc information, e.g., inviting evidence, calling witnesses, examining available documents, etc. It cannot decide, in advance, what information is needed to reach its conclusions and set up a system to gather that information.

For these reasons, a commission of the legislature (or similar body) may be best able to carry out an occasional, borad review of mental health legislation, allowing increasing public awareness in the process and seminal and progressive ideas to emerge. It is probably unrealistic, however, to expect such a body to carry out the detailed and ongoing monitoring and review necessary in a field as complex and specialized as mental health.

b) Ministerial review

Responsibility for mental health care is usually vested with the health ministry, although in a number of countries services for the mentally retarded are either wholly, or in part, the responsibility of other ministries. It therefore appears reasonable that health ministries should be involved in the ongoing review of mental health legislation. It is difficult to see how this could be done in the absence of a section or unit concerned with mental health, and these have not yet been established in all countries. It is known that such mental health sections have often originated and applied pressure for legal changes in he past. The advantages of placing the onus of review within health ministries are as follows:

(i) the ministry is responsible for programme formulation and execution so that the review will be carried out in the context of overall programme goals;

(ii) the time frame allows a longitudinal as well as a cross-sectional assessment of legislation;

(iii) the ministry is likely to be in the best position for obtaining the information needed for the review.

There are, however, some disadvantages in assigning the review and monitoring as an internal function of the ministry. Firstly, there are clearly other sectors of government responsibility involved, for example, the police and the judiciary. Civil servants in one ministry are likely

to be wary of crossing ministerial lines in their recommendations. Secondly, if the review mechanism is completely in the hands of those responsible for programme implementation, objectivity in assessing services (and the role of legislation) may be difficult to achieve. Thirdly, it may be difficult for psychiatrists, who are likely to be in positions of authority in mental health sections of health ministries, to carry out the review on their own; they may lack drafting skills or legal knowledge. Fourthly, an internal review lacks visibility. Public interest is unlikely to be stimulated. Outside bodies (or individuals) who may wish to express their views may be frustrated.

In general terms, it appears that the health ministry should be part of, but not responsible for, the whole review process. There is a natural tendency for ministries to prefer "manipulation" of existing law to the complex and time consuming process of enacting new laws. In the case of mental health legislation, multi-sectoral involvement and potential controversy are likely to reinforce the natural conservatism of a government department.

c) Professional groups and associations

Psychiatrists, psychiatric nurses, psychologists, social workers and other professionals have a strong motivation to improve mental health laws. Working under outdated or ineffective legislation is frustrating. These professional groups have first hand knowledge of how the law operates and the effect it has on patients. Their views and expertise are clearly of great importance. Furthermore, in many countries, it has been groups of mental health professionals who have realized and publicized the need for introducing or changing mental health legislation. Many professional psychiatric associations have a standing committee on legislation, which does in fact carry out an ad hoc review function. Such associations are hampered, however, by lack of official support for review activities. Furthermore, there is an inevitable tendency to view the problem from the standpoint of the profession concerned and to resist, what may be seen as "outside interference". There are historical examples of psychiatric associations resisting legal review mechanisms and underestimating the role of other groups. This is not necessarily due to bad faith or self interest, but stems from an under-

Mental health professionals must take part in review of legislation; their expertise and experience is indispensable. Professional associations are useful channels for this involvement. It would probably be a mistake, however, to rely entirely on activity within these associations. The public would rightly expect an independent counter balance.

d) Lay associations

There has been a growing movement of lay associations concerned with mental health, since the early part of the century (the story of Clifford Beers, his autobiographical book describing treatment in a large mental hospital and the founding of the National Council for Mental Hygiene is well known). Such associations now exist in many countries of the world (most being affiliated to the World Federation of Mental Health or, in the field of mental retardation, the International League of Societies for the Mentally Retarded). In some countries, associations have a network of local branches whichprovide various kinds of help and advice for mentally disordered people and their relatives as well as raising funds. Increasingly legal and rights matters are taken up both in general and for individual cases. In their early development, there was a tendency for such associations to be quasi-professional, i.e., many influential members were in fact psychiatrists, social or psychiatric nurses. Recently they have become increasingly independent and questioning of professional wisdoms. They naturally lobby strongly for the devotion of increased resources to mental health work.

In England and Wales, the National Association of Mental Health (a lay organization) has recently carried out and published a review of mental health legislation which has provoked a good deal of debate. In the field of mental retardation, associations have been active in sponsoring test cases to establish the rights of retarded people, particularly in the United States.

Such associations therefore seem to be in a good position to contribute to legislative review more than in the past. They are increasingly independent, they have direct involvement with individuals affected by mental health laws and they are concerned with improving mental health care. Furthermore, they are usually able to call upon professional advice from both the psychiatric and the legal field. Possible weaknesses are: firstly, a lack of compre-

involvement in programme planning and execution (and a lack of awareness of resource constraints that are involved); thirdly, their recommendations tend to be seen as special pleading for one group and may therefore be discounted, and, fourthly, there is always a risk that lay associations may be unduly influenced by (or even penetrated and take over by small groups with) extreme views.

e) Academic institutions

Universities, legal institutes and other academic bodies have a number of qualities which equip them for an effective review function. Their staff are relatively independent of government or professional pressures. They are in a position to adopt a multidisciplinary approach. Research workers are trained to gather and critically review relevant information. Staff are readily able to draw information from library sources and are likely to be aware of historical precendents and trends. They may also have strong international links and can make useful cross-national comparisons. An academic review is therefore likely to be broad based, incisive and unparochial. Such academic institutions specializing in legal medicine are relatively few, and their sphere of interest is much wider than mental health legislation alone. As a result, although academic work can provide critical and objective stimulus and challenge the appropriateness of existing solutions, in most cases such work could not be the source of a regular and reliable review process. Research must, to some extent, reflect the interests of academic staff. Furthermore, universities tend to be divorced from the realities of programme activities. the trend towards strengthening of links between universities and government services may decrease these limitations and increasing use could be made of research work commissioned by governments to illuminate crucial issues. Partnership in law drafting can also be a fruitful aspect of university/government collaboration.

f) Courts and tribunals

If the court system has to deal with a number of cases arising under existing mental health legislation, it may take on a review function. In legal arguments before the court, deficiences or lack of clarity in

the law may be exposed. In their judgements, the judiciary may provide a commentary on the law and its application which makes the need for change clear. In the case of appeals and dissenting opinions, an illuminating dialogue may develop, providing a powerful analysis of the legal situation. The high reputation of the judiciary ensures that such opinions are not ignored. Such a process can only operate, however, if cases come to court - and will be restricted to the issues raised by these cases. Much will depend on the interest and motivation of the judges concerned.

3. Towards a workable model

All the possibilities discussed above (the statutory commission, the health ministry, professional and lay associations, academic institutions and the courts) offer both advantages and disadvantages in achieving an ongoing evaluation of mental health legislation to indicate the need for timely and appropriate change. It may be useful to list the various advantageous factors identified in the different possibilities:

(i) public attention and prestige;

(ii) time and resources for a careful review process, including longitudinal assessments;

(iii) involvement of a range of professional groups with relevant expertise;

(iv) availability of information and ability to plan necessary information collection;

(v) lay participation;

(vi) involvement in programme planning and execution;

(vii) international links (governmental and non-governmental organizations, academic links, etc.);

(viii) research capability.

Should such a combination be sought in a single mechanism? Possibly not -some of the characteristics may indeed be incompatible. Parallel activity by the different bodies may provide the most effective process, with cross fertilization of ideas, a two way process of challenge and reaction and stimulation of debate. This kind of multiple, independent reviewing seems to be evolving in some countries (e.g., Canada, USA, the United Kingdom, Scandinavia and other European countries) but it requires a critical mass of highly trained manpower and a well informed public. It is unlikely to emerge as a meaningful process in many developing countries in the near future. Furthermore, in countries with centrally planned economics and social services, such heterogenous activities might be out of tune with usual practice. It may be useful, therefore, to suggest a single model which would have as many as possible of the characteristics listed above.

An interministerial standing advisory committee (ISAC) could provide such a model. Its chairman and members would be jointly appointed by those ministers with responsibility for health care, social and welfare services, the police and the judiciary. The secretariat would be drawn from the health ministry (specifically from the mental health section). The committee would be informed directly of the national mental health policy and programme and would have access to the national health information system (including being able to request the collection of additional data). The committee members would include: one or more members of the legislature; senior civil servants from the ministries involved; at least two lawyers and a judge; senior mental health professionals (including those representing professional associations); representatives of lay mental health associations, an academician and one or more additional members. Total membership would not be more than 20. Such a committee need meet no more than once or twice annually. The aim would be not simply to proivde a forum for discussion and exchange of views but to initiate and maintain a cycle in which mental health programme objectives were reviewed, the potential contribution (or negative effect) of existing legislation identified and a series of objectives for such legislation agreed upon. Information to be gathered (as part of the national health information system) to enable an evaluation of the extent to which these objectives were achieved (or to which postulated negative effects were in fact operating) would be specified. Information on international trends would

be provided by WHO. At a subsequent meeting, this information would be reviewed and if objectives were not being achieved, possible legal or administrative changes would be considered. Recommendations would be made directly to the government in a report which could receive wide publicity. The process would therefore take place outside the civil service, but with support and information input from a civil service secretariat.

The suggested model is a hybrid; it might suffer from bureaucratic inertia and in many countries modifications would obviously be necessary. Some mechanism of this kind may, however, be the only way to ensure prestige, wide representation, relevant information input, necessary expertise, an adequate secretariat and independent opinions.

4. The review process

Above is described a possible model of an interministerial standing advisory committee with wide representation and an effective secretariat which could provide the vehicle for ongoing review and monitoring of mental health legislation. So far, however, the review process itself has been considered only in passing.

It is assumed that, prior to instituting an ongoing review process, there will have been a comprehensive and careful assessment of existing legislation and that changes found to be necessary will have been carried out. In countries with no formal legal provisions for the mentally ill, a decision to adopt such legislation would have been taken. If it is decided not to attempt to link legislation with programme goals, an ongoing review process is not needed (although the decision should be reviewed from time to time). Such a decision may be taken in those countries with relatively little reliance on formal law in the field of social action where formal mental health legislation might be exceptional and therefore undesirable.

In any comprehensive review of legislation leading to recommendations for immediate change, the possibility of further modifications in the future should also be considered. In some situations a policy of step by step development may be more effective than a radical legislative overhaul. In other situations, some new measures would be regarded as experimental and requiring review after a specified period. If the position is taken that new laws need not be immutable, it is more likely that innovative approaches adapted to country needs will be forthcoming.

The first step in the ongoing review process would be to set and define the

overall objectives of the national mental health programme but would specify to which aspects of the national programme objectives legislation might contribute. Examples of such objectives might be:

(a) to decrease the proportion of involuntary admissions to mental hospitals;
(b) to promote community-based treatment of priority conditions;
(c) to expedite access to treatment for patients living in remote rural areas;
(d) to limit the number of chronically hospitalized patients;
(e) to provide early treatment for acutely disturbed mentally ill individuals;
(f) to protect the public from potentially dangerous psychotic individuals;
(g) to define responsibility for the development of mental health care;
(h) to stimulate communities to participate in mental health care.

Such a list could be extended, but it would be realistic to limit the number of objectives in a country at any one time to those which reflect the most pressing needs. Wherever possible, objectives should be quantifiable and targets should be set for a 2-5 year period. Great care is needed in defining and quantifying objectives; for example, if a decrease in involuntary hospital admissions is defined as an objective and quantified in absolute numbers during a period in which hospital facilities are extended, a rise in the absolute number of involuntary admissions may coincide with a fall in the proportion of involuntary to voluntary (or informal) admissions. Similarly, the objectives of promoting community-based psychiatric treatment might be quantified in terms of the number of ambulatory clinic attendances, home visits and other extra-mural patient/care giver contacts. This may be misleading since the type of patient seen is not known. Large numbers of people with minor, self-limiting disorders may be seen while the seriously ill are not reached. Here, epidemiological data and skills are needed so that different patient groups can be defined and estimates of prevalence of certain disorders made. If, for example, working predictions of the number of acute psychiatric emergencies occuring over one year, the number of moderately-severely mentally retarded children and the number of patients with schizophrenia can be made for a given community, targets for various kinds of patient care can be set.

In some instances, it will be difficult to quantify objectives precisely but indirect indicators can be used; for example, the objective of stimulating community participation in mental health care could be assessed by the membership of mental health associations, by the number of visitors to mental hospitals or by the unemployment rate of discharged patients (adjusted for overall changes in unemployment levels).

The second stage in the review process would be the collection of information by which the extent to which objectives are reached can be assessed. This should be done, as far as possible, as part of the national mental health information system. Some limited additional data gathering may be necessary, and this should be built into the existing system, for example by modifying data sheets. To give an example of a need for such additional data: if a stated objective of legislation is to ensure rapid access to treatment of acutely disturbed patients, the time between first contact with any social agency (e.g. police) and receiving treatment could be recorded on admission for all emergency cases and included in monthly statistical returns.

Data of this kind can be analysed in three ways:

(a) by seeing whether the targets set for the various objectives have been reached or surpassed;

(b) by observing changes over time;

(c) by comparing different geographical areas within the country, to establish whether some legal provisions are used disproportionately in certain areas and whether national trends represent an even rate of change throughout the country.

The process, as described up to this point, would consist of (a) defining objectives (and wherever possible quantified targets); (b) data collection and (c) data analysis. The aim would be to allow a review committee to assess whether stated objectives of legislation were being achieved over a given period, since failure to do so would clearly constitute a possible indication for legislative change.

The review committee would need other kinds of information.

Firstly, administrative measures taken to implement existing legislation should be described by the relevant ministry. In some countries there have been considerable delays in implementing newly enacted legislation. The committee would examine the reasons for any such delays and suggest how they may be overcome.

Secondly, information on changes in the organization and pattern of general health services would be relevant. In many countries, radical shifts in health service policy are being considered, for example, (a) placing emphasis on extension and accessibility of health care through primary health workers with a relatively brief training working in close collaboration with communities; (b) unification of services, in countries which at present have both social security and government systems; (c) sectorisation, regionalisation and de-centralization. Such changes which alter the availability of existing personnel, the responsibility for planning and the extent of community involvement and lead to the employment of new kinds of health personnel, may call for changes in mental health legislation (or at least its administration). Policy changes relating specifically to mental health care would be of particular importance; for example, the establishment of psychiatric units in general hospitals, out-patient clinics in health centres or other extensions would be reported in detail to a review committee so that the legal implications can be carefully considered.

Thirdly, the review committee would wish to examine whether new methods of treatment or approaches to mental health care meant that new, more ambitious objectives could be set (or, alternatively, that former objectives were unrealistic and over-ambitious). Information on technological advances (e.g. new forms of

drug therapy, behavioural treatments) and training methods should therefore be available. It may be considered that simpler, effective treatments make it possible to widen the range of personnel actively involved in treatment. Advances in therapeutic methods may also call for additional legal provisions of control.

Fourthly, information concerning the protection of patients' rights should be sought. This is a difficult area in which to be objective but some quantitative data would be useful, for example, the number of letters despatched by patients from hospital in a specified period; the rate of utilization of different commitment procedures (to establish whether "emergency provisions" are being overused to circumvent standard admission procedures which have more safeguards and are therefore more complex , the number of patients using appeals procedures and the outcome of such appeals (if very few appeals were forthcoming); this may be because patients are either unaware or unable to use such procedures; if a very large number is recorded, this may indicate that provisions are not being properly applied). Such quantitative data would be supplemented by more impressionistic material sought from a variety of sources - mental health associations, professional groups and possibly patients themselves.

Fifthly, an assessment of "public attitudes" concerning mental health would be needed. Clearly, there is no such thing as a uniform set of "public attitudes", but some indications of additudinal shifts, areas of concern, level of prejudice, fears, interests among the public, etc. may be discerned. Press and other media coverage of mental health issues could be reviewed. In some cases, there may be a place for a limited sociological study. The aim would be to establish (a) whether the hoped for educational function of the law was taking place; (b) the need for legal provisions controlling certain kinds of treatment or admission procedure to restore or maintain public confidence; (c) whether the climate of public opinion would be favourable to provisions which would lead to more patients being treated in the community.

The review committee would thus be furnished with information which it itself would have requested. A series of questions would then be posed:

Has the law performed as well as expected? If not, what modifications would allow the original objectives to be achieved?

Have changes in the health care system or newly available methods of diagnosis or management created a need for new legal provisions?

Is there public concern or anxiety which would justify additional legal controls or checks?

Are patients' rights and interests adequately protected?

In answering these questions, value judgments must be applied and can be debated. The committee would, however, be expected to reach agreement and formulate a series of recommendations concerning both legal and administrative provisions. In doing this, several practical issues would be important. The committee should take into account the cost of administering legislation, particularly in terms of manpower resources. Review procedures, court hearings, independent medical examinations use resources which could otherwise be applied to service provision. This is not meant to imply that basic principles can be compromised, but that realistic solutions should be sought reserving as far as possible the most highly trained personnel (both psychiatric and legal) for the tasks only they can perform. Lay magistrates, traditional leaders, nurses, medical assistants and others could also play an important part in the operation of the law. The practical problems of enacting new laws should also be considered. Many legislatures are grossly overloaded with business and serious delays in legislative programmes are common. Political instability, ministerial changes and scarcity of legal drafters bring further delays. Frequent statutory changes are unlikely to be feasible. Simple amendments may be considered once every two to three years, but major changes (e.g. a completely new law) could probably only be introduced once in 10-15 years. On the other hand, administrative provisions can be changed more readily (usually by a ministerial instruction) and can lead to substantial improvements in the operation of the law. A minister is likely to feel more secure in making such changes if he has the support of such an independent review committee.

What is the potential role of WHO in such a review process? WHO could provide assistance in the methodology needed, for example the development of information systems, data analysis, assessment of public attitudes. Information on new approaches to mental health care introduced in different countries could be provided and WHO could also provide information on legislative trends. The International Digest of Health Legislation is useful in this respect. If a number of countries indicate an interest in establishing a regular review process, it would be possible to link these and provide regular information not only on legislation itself but also on the way it operates and on the review mechanisms in use in different countries.

The international aspect of mental health legislation could then take on new meaning. Whereas in the past there has been a one way, linear exchange, with one or two influential laws being used as a model for many countries, a collaborative network could be evolved so that each country could draw on